



WellDyne RxWEST PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS:

1. Fill out all of the information on the claim form as completely as possible.
2. **Please complete a separate claim form for each family member.**
3. Provide an original receipt with prescription details from your pharmacy. Cash register tape and photo copies will not be accepted.
4. If necessary, contact the pharmacist to provide the detailed drug information requested on the form for the prescription(s) dispensed.
5. Please provide the complete name, address and telephone number of the pharmacy. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number **888-479-2000** You can reach us between the hours of 8:00 a.m. and 5:00 p.m. (MST), Monday through Friday.
6. Mail the completed form and original receipts directly to:

WellDyne RxWEST
PO Box 4517
ENGLEWOOD, CO 80155

7. You will receive a response within 30 days.

***Use this form to be reimbursed for each prescription that you purchased without your prescription card.
You will be reimbursed network pharmacy rates, less co-pays.***

EMPLOYEE INFORMATION			PATIENT INFORMATION		
Employer's Name	Group Number		Patient's Last Name	Middle Initial	First Name
Last Name	Middle Initial	First Name	Birthdate (mo/day/yr)		
Cardholder ID#			Male <input type="checkbox"/> Female <input type="checkbox"/>		
Address			Patient's Relationship to Employee:		
City, State, Zip Code			Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
Daytime Phone Number					
PRESCRIPTION # 1 INFORMATION			PRESCRIPTION # 2 INFORMATION		
Rx Number	Date Filled		Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid	Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name			Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg.,ml.,etc.)			Medication Name and Strength (mg.,ml.,etc.)		
NDC Number			NDC Number		
Is the Drug: (Check All That Apply)			Is the Drug: (Check All That Apply)		
<input type="checkbox"/> New Prescription <input type="checkbox"/> Refill			<input type="checkbox"/> New Prescription <input type="checkbox"/> Refill		
<input type="checkbox"/> Compound Rx <input type="checkbox"/> Allergy Injectable			<input type="checkbox"/> Compound Rx <input type="checkbox"/> Allergy Injectable		

